DEPARTMENT OF CONSUMER AND REGULATORY AFFAIRS

NOTICE OF FINAL RULEMAKING

The Superintendent of Insurance, Insurance Administration, Department of Consumer and Regulatory Affairs (DCRA), pursuant the "Medicare Supplement Insurance Minimum Standards Act of 1992", D.C. Law 9-170 (D.C. Code, Secs. 35-2201 - 35-2209 et seq.), hereby gives notice of the adoption on May 3, 1993 of the following new Chapter 22 Title 26 DCMR, "Insurance". A Notice of Emergency and Proposed Rulemaking was published in the D.C. Register on October 9, 1992 at 39 DCR 7590 - 7657.

Legislation was submitted to the U.S. Department of Health and Human Services, Health Care Finance Administration, and approval was made on July 30, 1992. The Federal standards mandated under Section 1882 of the Social Security Act (Act) as amended by the Omnibus Budget Reconciliation Act of 1990, approved November 5, 1990 (P. L. 101-508) were met.

Pursuant to Section 412 of the District of Columbia Self-Government and Governmental Reorganization Act, P. L. 93-198, "the Act", the Council of the District of Columbia adopted Bill No. 9-459 on first and second readings, June 2, 1992, and July 7, 1992, respectively. Following the signature of the Mayor on July 23, 1992, this legislation was assigned Act No. 9-268, published in the August 7, 1992, edition of the D.C. Register, (Vol. 39 Page 5825) and transmitted to Congress on July 27, 1992 for a 30 day review, in accordance with Section 602(c)(1) of the Act.

A Notice of Final Rulemaking was published in the Register on May 21, 1993 at 40 DCR 3317. The Notice of Final Rulemaking inadvertently omitted certain pages including charts and appendices. The entire text of the Rulemaking is being republished for purposes of clarity.

Chapter 22 MEDICARE SUPPLEMENT INSURANCE MINIMUM STANDARDS

2200 PURPOSE.

2200.1 The purpose of this chapter is:

(a) To provide for the reasonable standardization of coverage and simplification of terms and benefits of Medicare supplement policies;

(b) To facilitate public understanding and comparison of such policies;

(c) To eliminate provisions contained in such policies which may be misleading or confusing in connection with the purchase of such policies or with the settlement of claims; and

(d) To provide for full disclosure in the sale of accident and sickness insurance coverages to persons eligible for Medicare.

2201 AUTHORITY.

This chapter is issued pursuant to the authority vested in the Superintendent of Insurance under the Medicare Supplement Insurance Minimum Guidelines Emergency Act of 1992, approved April 24, 1992 and similar temporary and permanent legislation, see Bill 9-48 and Bill 9-459, D.C. Code 35-2611, 1981 Edition, (as amended).

2202 APPLICABILITY AND SCOPE.

2202.1 Except as otherwise specifically provided in sections 2206, 2211, 2212, and 2226, this chapter shall apply to:

(a) All Medicare supplement policies delivered or issued for delivery in the District of Columbia on or after July 22, 1992; and

(b) All certificates issued under group Medicare supplement policies which certificates have been delivered or issued for delivery in the District of Columbia.

2202.2 This chapter shall not apply to:

(a) A policy or contract of one or more employers or labor organizations; or

(b) The trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

2203 RESERVED

2204 POLICY DEFINITIONS AND TERMS.

2204.1 No policy or certificate may be advertised, solicited or issued for delivery in the District of Columbia as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this section.

2204.2 **"Accident," "Accidental Injury,"** or **"Accidental Means"** shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

(a) The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident, independent of disease or bodily infirmity or any other cause, and occurs while insurance coverage is in force."

(b) Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no-fault plan, unless prohibited by law.

2204.3 **"Benefit Period"**or **"Medicare Benefit Period"** shall not be defined more restrictively than as defined in the Medicare program.

2204.4 **"Convalescent Nursing Home," "Extended Care Facility,"** or **"Skilled Nursing Facility"** shall not be defined more restrictively than as defined in the Medicare program.

2204.5 **"Health Care Expenses"** means expenses of health maintenance organizations associated with the delivery of health care services, which expenses are analogous to incurred losses of insurers and such expenses shall not include:

(a) Home office and overhead costs;
(b) Advertising costs;
(c) Commissions and other acquisition costs;
(d) Taxes;
(e) Capital costs;
(f) Administrative costs; and
(g) Claims processing costs.

2204.6 **"Hospital"**may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals, but not more restrictively than as defined in the Medicare Program.

2204.7 **"Medicare"** shall be defined in the policy and certificate and may be substantially defined as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended," or "Title I, Part I of Public Law 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof," or words of similar import.

2204.8 **"Medicare Eligible Expenses"** shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

2204.9 **"Physician"** shall not be defined more restrictively than as defined in the Medicare program.

2204.10 "Sickness" shall not be defined to be more restrictively than the following:

(a) An illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force.

(b) The definition excludes sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

2205 POLICY PROVISIONS.

2205.1 Except for permitted preexisting condition clauses as described in paragraphs 2206.3(a) and 2207.3(a) of this chapter, no policy or certificate may be advertised, solicited or issued for delivery in the District of Columbia as a Medicare supplement policy if such policy or certificate contains limitations or exclusions on coverage that are more restrictive than those of Medicare.

2205.2 No Medicare supplement policy or certificate may use waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases or physical conditions.

2205.3 No Medicare supplement policy or certificate in force in the District of Columbia shall contain benefits which duplicate benefits provided by Medicare.

2206 MINIMUM BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED FOR DELIVERY PRIOR TO JULY 22, 1992.

2206.1 No policy or certificate may be advertised, solicited or issued for delivery in the District of Columbia as a Medicare supplement policy or certificate unless it meets or exceeds the following Minimum Standards.

2206.2 The standards contained in subsections 2206.3 (General Standards) and 2206.4 (Minimum Benefit Standards) are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

2206.3 The following General Standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this chapter.

(a) A Medicare supplement policy or certificate shall not;

(1) Exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition; and

(2) Define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(b) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors, and premiums may be modified to correspond with such changes.

(d) A"**noncancellable," "guaranteed renewable,"** or **"noncancellable and guaranteed renewable"** Medicare supplement policy shall not:

(1) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium; or

(2) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.

(e) Except as authorized by the Superintendent, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresenation.

(f) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection 2206.3(h), the issuer shall offer certificateholders an individual Medicare supplement policy and shall offer certificateholders at least the following choices:

(1) An individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(2) An individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in subsection 2207.4 of this chapter.

(g) If membership in a group is terminated, the issuer shall:

(1) Offer the certificateholder such conversion opportunities as are described in paragraph 2206.3(f): or

(2) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(h) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer:

(1) Shall offer coverage to all persons covered under the old group policy on its date of termination; and

(2) Shall not offer coverage under the new group policy shall not result in an exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(i) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

2206.4 The following Minimum Benefit Standards apply to Medicare supplement policies or certificates.

(a) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(b) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

(c) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;

(d) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;

(e) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;

(f) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible ($100); and,

(g) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations), unless replaced in accordance with federal regulations or already paid for

under Part A, subject to the Medicare deductible amount.

2207 BENEFIT STANDARDS FOR POLICIES OR CERTIFICATES ISSUED OR DELIVERED ON OR AFTER JULY 22, 1992.

2207.1 The standards contained in this section are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in the District of Columbia on or after July 22, 1992.

2207.2 No policy or certificate may be advertised, solicited, delivered or issued for delivery in the District of Columbia as a Medicare supplement policy or certificate unless it complies with these benefit standards.

2207.3 The following General Standards apply to Medicare supplement policies or certificates and are in addition to all other requirements of this chapter.

(a) A Medicare supplement policy or certificate shall not:

(1) Exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because it involved a preexisting condition; and

(2) Define a preexisting condition more restrictively than a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

(b) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

(c) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors and premiums may be modified to correspond with such changes.

(d) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.

(e) Each Medicare supplement policy shall be guaranteed renewable: and

(1) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual; and

(2) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation.

(3) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under subparagraph 2207.3(e)(5), the issuer shall offer certificateholders an individual Medicare supplement policy which, at the option of the certificateholder,

(A) Provides for continuation of the benefits contained in the group policy, or

(B) Provides for such benefits as otherwise meets the requirements of this subsection.

(4) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:

(A) Offer the certificateholder the conversion opportunity described in subparagraph 2207.3(e)(3), or

(B) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

(5) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the succeeding issuer:

(A) Shall offer coverage to all persons covered under the old group policy on its date of termination; and

(B) Shall not offer coverage under the new policy that results in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

(f) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

(g) A Medicare supplement policy or certificate shall provide that benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or

certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance. Upon receipt of timely notice, the issuer shall return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.

(h) If such suspension occurs pursuant to paragraph 2207.3(g) and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted, effective as of the date of termination of such entitlement, if the policyholder or certificateholder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

(j) Reinstitution of coverages:

(1) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

(2) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

(3) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

2207.4 The following standards for Basic ("Core") Benefits, common to all benefit plans, shall apply.

(a) Every issuer;

(1) Shall make available a policy or certificate including only the following Basic "Core" Package of Benefits, common to all benefits plans, to each prospective insured; and

(2) May make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the Basic "Core" Package of Benefits, but not instead of the Basic "Core" package of Benefits.

b) The Basic ("Core") Package of Benefits consists of the following;

(1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

(2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

(3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

(4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations; and

(5) Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

2207.5 The following Additional Benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by section 2208 of this chapter;

(a) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

(b) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for post hospital skilled nursing facility care eligible under Medicare Part A.

(c) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

(d) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(e) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or state law, and the Medicare-approved Part B charge.

(f) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(g) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

(h) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which are began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000), and for purposes of paragraph 2207.5(h), "emergency care" shall mean care needed immediately because of an injury or an illness of sudden and unexpected onset.

(i) Preventive Medical Care Benefit: Coverage for the following preventive health services:

(1) An annual clinical preventive medical history and physical examination that may include tests and services from Subparagraph (2) and patient education to address preventive health care measures.

(2) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

(A) Fecal occult blood test and/or digital rectal examination;

(B) Mammogram;

(C) Dipstick urinalysis for hematuria, bacteriuria and proteinauria;

(D) Pure tone (air only) hearing screening test, administered or ordered by a physician;

(E) Serum cholesterol screening (every five (5) years);

(F) Thyroid function test;

(G) Diabetes screening.

(3) Influenza vaccine administered at any appropriate time during the year and Tetanus and Diptheria booster (every ten (10) years).

(4) Any other tests or preventive measures determined appropriate by the attending physician.

(5) Reimbursement under paragraph (i) shall be for the actual charges up to one hundred percent (100%) of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any procedure covered by Medicare.

(j) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

(1) For purposes of paragraph 2207.5(j), the following definitions shall apply:

(A) **"Activities of daily living"** include, but are not limited to bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

(B) **"Care provider"** means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

(C) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not

be considered the insured's place of residence.

(D) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

(2) Coverage Requirements and Limitations.

(A) At-home recovery services provided must be primarily services which assist in activities of daily living.

(B) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

(C) Coverage is limited to:

(i) No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician and the total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment;

(ii) The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit;

(iii) One thousand six hundred dollars ($1,600) per calendar year;

(iv) Seven (7) visits in any one week;

(v) Care furnished on a visiting basis in the insured's home;

(vi) Services provided by a care provider as defined in this section;

(vii) At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded;

(viii) At-home recovery visits received

during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

(D) Coverage is excluded for:

(i) Home care visits paid for by Medicare or other government programs; and

(ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

(k) New or Innovative Benefits: An issuer may, with the prior approval of the Superintendent, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards and the new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

2208 **STANDARD MEDICARE SUPPLEMENT BENEFIT PLANS.**

2208.1 An issuer shall make available to each prospective policholder and certificateholder a policy form or certificate form containing only the Basic "Core" Benefits, as defined in subsection 2207.4 of this chapter.

2208.2 No groups, packages or combinations of Medicare supplement benefits other than those listed in this section shall be offered for sale in the District of Columbia, except as may be permitted in paragraph 2207.5(k).

2208.3 Benefit plans shall be uniform in structure, language, designation and format to the Standard Benefit Plans "A" through "J" listed in this subsection and conform to the definitions in section 2299 of this chapter.

2208.4 Each benefit shall be structured in accordance with the format provided in subsections 2207.4 and 2207.5 and list the benefits in the order shown in subsection 2208.7.

2208.5 For purposes of section 2208, "**structure, language**, and **format**" means style, arrangement and overall content of a benefit.

2208.6 An issuer may use, in addition to the benefit plan designations required in subsection 2208.3, other designations to the extent

permitted by law.

2208.7 Make-up of benefit plans:

(a) Standardized Medicare supplement benefit plan "A" shall be limited to the Basic ("Core") Benefits common to all benefit plans, as defined in subsection 2207.4 of this chapter.

(b) Standardized Medicare supplement benefit plan "B" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible as defined in paragraph 2207.5(a).

(c) Standardized Medicare supplement benefit plan "C" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible and Medically Necessary Emergency Care in a Foreign Country as defined in paragraphs 2207.5(a), (b), (c) and (h) respectively.

(d) Standardized Medicare supplement benefit plan "D" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in an Foreign Country and the At-Home Recovery Benefit as defined in paragraphs 2207.5(a) and (b),(h), and (j) respectively.

(e) Standardized Medicare supplement benefit plan "E" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medically Necessary Emergency Care in a Foreign Country and Preventive Medical Care as defined in paragraphs 2207.5(a), (b), (h), and (i) respectively.

(f) Standardized Medicare supplement benefit plan "F" shall

include only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible, the Skilled Nursing Facility Care, the Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, and Medically Necessary Emergency Care in a Foreign Country as defined in paragraphs 2207.5(a), (b), (c), (e), and (h) respectively.

(g) Standardized Medicare supplement benefit plan "G" shall include only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible, the Skilled Nursing Facility Care, Eighty Percent (80%) of the Medicare Part B Excess Charges, Medically Necessary Emergency Care in a Foreign Country, and the At-Home Recovery Benefit as defined in paragraphs 2207.5(a), (b), (d), (h), and (j) respectively.

(h) Standardized Medicare supplement benefit plan "H" shall consist of only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Basic Prescription Drug Benefit and Medically Necessary Emergency Care in a Foreign Country as defined in paragraphs 2207.5(a), (b), (f), and (h) respectively.

(i) Standardized Medicare supplement benefit plan "I" shall consist of only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Basic Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country and At-Home Recovery Benefit as defined in paragraphs 2207.5(a), (b), (e), (f), (h), and (j) respectively.

(j) Standardized Medicare supplement benefit plan "J" shall consist of only the following:

(1) The Core Benefit as defined in subsection 2207.4 of this chapter; plus

(2) The Medicare Part A Deductible, Skilled Nursing Facility Care, Medicare Part B Deductible, One Hundred Percent (100%) of the Medicare Part B Excess Charges, Extended Prescription Drug Benefit, Medically Necessary Emergency Care in a Foreign Country, Preventive Medical Care and At-Home Recovery Benefit as defined in paragraphs 2207.5(a), (b), (c), (e), (g), (h), (i), and (j) respectively.

2209 RESERVED

2210 OPEN ENROLLMENT

2210.1 No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale or delivery in the District of Columbia, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant where an application for such policy or certificate is submitted during the six (6) month period beginning with the first month in which an individual, who is 65 years of age or older, first enrolled for benefits under Medicare Part B.

2210.2 Each Medicare supplement policy and certificate currently available from an insurer shall be made available to all applicants who qualify under subsection 2210.1 without regard to age.

2210.3 Subsections 2210.1 and 2210.2 shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before it became effective.

2211 STANDARDS FOR CLAIMS PAYMENT.

2211.1 An issuer shall comply with section 1882(c)(3) of the Social Security Act (as enacted by section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) 1987, Pub. L. No. 100-203) by:

(a) Accepting a notice from a Medicare carrier on duly assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;

(b) Notifying the participating physician or supplier and the beneficiary of the payment determination;

(c) Paying the participating physician or supplier directly;

(d) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number and a central mailing address to which notices from a Medicare carrier may be sent;

(e) Paying user fees for claim notices that are transmitted electronically or otherwise; and

(f) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

2211.2 Compliance with the requirements set forth in subsection 2211.1 shall be certified on the Medicare supplement insurance experience reporting form.

2212 LOSS RATIO STANDARDS

2212.1 A Medicare supplement insurance policy form or certificate form shall not be delivered or issued for a delivery in the District of Columbia unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificate holders in the form of aggregate benefits (not including anticipated refunds or credits as described in section 2213) provided under the policy form or certificate form:

(a) At least seventy-five percent (75%) of the aggregate amount of premiums earned in the case of group policies; or

(b) At least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies.

2212.2 The loss ratios set forth in subsection 2212.1 shall be calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis and earned premiums for such period and in accordance with accepted actuarial principles and practices.

2212.3 All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of section 2212 when combined with actual experience to date.

2212.4 Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

2212.5 For purposes of applying subsections 2212.1, 2212.2 and section 2216 only, policies issued as a result of solicitations of

individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

2213 **REFUND OR CREDIT OF PREMIUM.**

2213.1 An issuer shall collect and file with the Superintendent by May 31 of each year the data contained in the reporting form contained in Appendix A for each type in a Standard Medicare Supplement Benefit Plan, described in section 2208 of this chapter.

2213.2 If on the basis of the experience as reported the benchmark loss ratio since inception (ratio 1) exceeds the adjusted experience loss ratio since inception (ratio 3), then a refund or credit calculation is required.

(a) The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan.

(b) For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

2213.4 A refund or credit shall be made only when:

(a) The benchmark loss ratio exceeds the adjusted experience loss ratio; and

(b) The amount to be refunded or credited exceeds a de minimis level.

2213.5 The refund or credit described in subsection 2213.4, shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest of 13 week Treasury notes.

2213.6 A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

2214 **ANNUAL FILING OF PREMIUM RATES.**

2214.1 An issuer of Medicare supplement policies and certificates issued before or after the effective date of the Medicare Supplement Insurance Minimum Emergency Standards in the District of Columbia shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Superintendent of Insurance in accordance with the filing requirements and procedures prescribed by the Superintendent.

2214.2 The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions,

that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed and such demonstration shall exclude Active Life Reserves.

2214.3 An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

2214.4 As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in the District of Columbia shall file with the Superintendent, in accordance with the applicable filing procedures of the District of Columbia:

(a) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates; and

(b) Supporting documents as necessary to justify the adjustment.

2214.5 An issuer shall make premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies and certificates.

2214.6 No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

2214.7 If an issuer fails to make premium adjustments acceptable to the Superintendent, the Superintendent may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by section 2212.

2214.8 Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare and the riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

2215 PUBLIC HEARINGS.

2215.1 The Superintendent may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after July 22, 1992, if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard.

2215.2 The determination of compliance is made without consideration of any refund or credit for such reporting period.

2215.3 Public notice of such hearing shall be furnished in a manner deemed appropriate by the Superintendent.

2216 **FILING AND APPROVAL OF POLICIES AND CERTIFICATES AND PREMIUM RATES.**

2216.1 An issuer shall not:

(a) Deliver or issue for delivery a policy or certificate to a resident of the District of Columbia unless the policy form or certificate form has been filed with and approved by the Superintendent of Insurance in accordance with filing requirements and procedures prescribed by the Superintendent; and

(b) Use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Superintendent of Insurance in accordance with the filing requirements and procuedures prescribed by the Superintendent.

2216.2 Except as provided in subsection 2216.3, an issuer shall not file for approval more than one form of a policy or certificate of each type for each Standard Medicare Supplement Benefit Plan described in section 2208.

2216.3 An issuer may offer, with the approval of the Superintendent, up to four (4) additional policy forms or certificate forms of the same type for the same Standard Medicare Supplement Benefit Plan, one for each of the following cases:

(a) The inclusion of new or innovative benefits;

(b) The addition of either direct response or agent marketing methods;

(c) The addition of either guaranteed issue or underwritten coverage; and

(d) The offering of coverage to individuals eligible for Medicare by reason of disability.

2216.4 For the purposes of section 2216, a "type" means an individual policy or a group policy.

2216.5 Except as provided in subsections 2216.7 and 2216.8, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this chapter that has been approved by the Superintendent.

2216.6 A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve (12) months.

2216.7 An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Superintendent in writing its decision at least thirty (30) days prior to discontinuing the availability of the form of the policy or certificate.

2216.8 After receipt of the notice by the Superintendent, evidenced by the Superintendent's stamp, the issuer shall no longer offer for sale the policy form or certificate form in the District of Columbia.

2216.9 An issuer that discontinues the availability of a policy form or certificate form pursuant to subsections 2216.7 and 2216.8 shall not file for approval a new policy form or certificate form of the same type for the same Standard Medicare Supplement Benefit Plan as the discontinued form for a period of five (5) years after the issuer provides notice to the Superintendent of the discontinuance.

2216.10 The period of discontinuance may be reduced if the Superintendent determines that a shorter period is appropriate.

2216.11 The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of subsections 2216.5, 2216.6, 2216.7, 2216.8, 2216.9. and 2216.10.

2216.12 A change in the rating structure or methodology shall be considered a discontinuance under subsections 2216.5, 2216.6, 2216.7, 2216.8, and 2216.9, and 2216.10, unless the issuer complies with the following requirements:

(a) The issuer provides an actuarial memorandum, in a form and manner prescribed by the Superintendent, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing rates.

(b) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the actuarial memorandum to change.

(c) The Superintendent may approve a change to the differential which is in the public interest.

2216.13 Except as provided in subsection 2216.11;

(a) The experience of all policy forms or certificate forms of the same type in a Standard Medicare Supplement Benefit Plan

shall be combined for purposes of the refund or credit calculation prescribed in section 2213.

(b) Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

2217 PERMITTED COMPENSATION ARRANGEMENTS

2217.1 An issuer or other entity may provide commission or other compensation to an agent or other representative for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than two hundred percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

2217.2 The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five (5) renewal years.

2217.3 No issuer or other entity shall provide compensation to its agents or other producers and no agent or producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced.

2217.4 For purposes of section 2217 **"compensation"** includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

2218 REQUIRED DISCLOSURE PROVISIONS - GENERAL RULES.

2218.1 Medicare supplement policies and certificates shall:

include a renewal or continuation provision and the language or specifications of such provision shall be consistent with the type of contract issued.

2218.2 The renewal or continuation provision shall:

(a) Be appropriately captioned;

(b) Appear on the first page of the policy; and

(c) Include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2218.3 Except for riders or endorsements by which the issuer effectuates a request made in writing by the insured, exercises a specifically reserved right under a Medicare supplement policy, or is required

to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require a signed acceptance by the insured.

2218.4 After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term shall be agreed to in writing signed by the insured, unless the benefits are required by the Minimum Standards for Medicare Supplement Policies, or if the increased benefits or coverage is required by law.

2218.5 Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

2218.6 Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary" or words of similar import.

2218.7 If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as **"Preexisting Condition Limitations."**

2218.8 Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

2218.9 Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, other than incidentally, to a person(s) eligible for Medicare by reason of age shall provide to such applicants a Medicare Supplement Buyer's Guide in the form developed jointly by the National Association of Insurance Commissioners and the Health Care Financing Administration and in a type size no smaller than 12 point type. Delivery of the Buyer's Guide shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this chapter.

(a) Except in the case of direct response issuers, delivery of the Buyer's Guide shall be made to the applicant at the time of application and acknowledgment of receipt of the Buyer's Guide shall be obtained by the issuer.

(b) Direct response issuers shall deliver the Buyer's Guide to the applicant upon request but not later than at the time

the policy is delivered.

2219 REQUIRED DISCLOSURE PROVISIONS - NOTICE REQUIREMENT.

2219.1 As soon as practicable, but no later than thirty (30) days prior to the annual effective date of any Medicare benefit changes, an issuer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in a format acceptable to the Superintendent.

2219.2 Notice shall:

(a) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate; and

(b) Inform each policyholder or certificateholder as to when any premium adjustments is to be made due to changes in Medicare.

2219.3 The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension.

2219.4 Such notices shall not contain or be accompanied by any solicitation.

2220 REQUIRED DISCLOSURE PROVISIONS - OUTLINE OF COVERAGE REQUIREMENTS FOR MEDICARE SUPPLEMENT POLICIES.

2220.1 Issuers shall:

(a) Provide an outline of coverage to all applicants at the time application is presented to the prospective applicant; and,

(b) Except for direct response policies, obtain an acknowledgment of receipt of such outline from the applicant; and

2220.2 If an outline of coverage is provided at the time of application and the Medicare supplement policy or certificate is issued on a basis which would require revision of the outline, a substitute outline of coverage properly describing the policy or certificate shall:

(a) Accompany such policy or certificate when it is delivered and

(b) Contain the following statement, in no less than twelve (12) point type, immediately above the company name:

"NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued."

2220.3 The outline of coverage provided to applicants pursuant to section 2220 consists of four parts:

(a) A cover page;

(b) Premium information;

(c) Disclosure pages; and

(d) Charts displaying the features of each benefit plan offered by the issuer.

2220.4 The outline of coverage shall be in the language and format prescribed in subsection 2220.9, in no less than twelve (12) point type.

2220.5 All plans A-J shall be shown on the cover page; and the plan(s) that are offered by the issuer shall be prominently identified.

2220.6 Premium information for plans that are offered shall be:

(a) Shown on the cover page or immediately following the cover page; and

(b) Prominently displayed.

2220.7 The premium and mode shall be stated for all plans that are offered to the prospective applicant.

2220.8 All possible premiums for the prospective applicant shall be illustrated.

2220.9 The following items shall be included in the outline of coverage in the order prescribed below.

[COMPANY NAME]

Outline of Medicare Supplement Coverage—Cover Page.
Benefit Plan(s) [insert letter(s) of plan(s) being offered]

Medicare supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every company must make available Plan "A." Some plans may not be available in your state.

BASIC BENEFITS: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (20% of Medicare-approved expenses).
Blood: First three pints of blood each year.

A	B	C	D	E	F	G	H	I	J
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance	Skilled Nursing Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (100%)		Part B Excess (100%)	Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery			At-Home Recovery		At-Home Recovery	At-Home Recovery
							Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)	Basic Drugs ($1,250 Limit)
				Preventive Care					Preventive Care

PREMIUM INFORMATION [Boldface Typed]

We [insert issuer's name] can only raise your premium if we raise the premium for all policies like yours in the District of Columbia. [If the premium is based on the increasing age of the insured, include information specifying when premiums will change.]

DISCLOSURES [Boldface Type]

Use this outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY [Boldface Type]

This is only an outline describing your policy's most important features. The policy is your insurance contract. You must read the policy itself to understand all of the rights and duties of both you and your insurance company.

RIGHT TO RETURN POLICY [Boldface Type]

If you find that you are not satisfied with your policy, you may return it to [insert issuer's address]. If you send the policy back to us within 30 days after you received it, we will treat the policy as if it had never been issued and return all of your payments.

POLICY REPLACEMENT [Boldface Type]

If you are replacing another health insurance policy, do NOT cancel it until you have actually received your new policy and are sure you want to keep it.

NOTICE [Boldface Type]

This policy may not fully cover all of your medical costs.

[for agents:]

Neither [insert company's name] nor its agents are connected with Medicare.

[for direct response:]

[insert company's name] is not connected with Medicare.

This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security Office or consult "The Medicare Handbook" for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT [Boldface Type]

When you fill out the application for the new policy, be sure to answer truthfully and completely all questions about your medical and health history. The company may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Review the application carefully before you sign it. Be certain that all

information has been properly recorded.

[Include for each plan prominently identified in the cover page, a chart showing the services, Medicare payments, plan payments and insured payments for each plan, using the same language, in the same order, using uniform layout and format as shown in the charts below. No more than four plans may be shown on one chart. For purposes of illustration, charts for each plan are included in this chapter. An issuer may use additional benefit plan designations on these charts pursuant to Subsection 2208.6 of this chapter.]

[Include an explanation of any innovative benefits on the cover page and in the chart, in a manner approved by the Superintendent.]

PLAN A

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$0	$[652] (Part A Deductible)
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	$0	Up to $[81.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN A

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN B

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A Deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	$0	Up to $[81.50] a day
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN B

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES— IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

PLAN C

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A Deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for out patient drugs and inpatient respite care	$0	Balance

PLAN C

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0
PARTS A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A Deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN D

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN D (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN E

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A Deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN E

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN E (continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA First $250 each calendar year Remainder of Charges	 $0 $0	 $0 80% to a lifetime maximum benefit of $50,000	 $250 20% and amounts over the $50,000 lifetime maximum
PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare First $120 each calendar year Additional charges	 $0 $0	 $120 $0	 $0 All Costs

PLAN F

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A Deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN F

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN G

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A Deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements,including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN G

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	80%	20%
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN G (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	

OTHER BENEFITS—NOT COVERED BY MEDICARE

FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN H

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

* A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A Deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN H

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment,			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	$0	All Costs
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN H (continued)

OTHER BENEFITS—NOT COVERED BY MEDICARE

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN I

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A Deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN I

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges (Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

(continued)

PLAN I (continued)

PARTS A & B

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$0	$100 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	$0
AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE			
Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL—NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges*	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
BASIC OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $2,500 each calendar year	$0	50%—$1,250 calendar year maximum benefit	50%
Over $2,500 each calendar year	$0	$0	All Costs

PLAN J

MEDICARE (PART A)—HOSPITAL SERVICES—PER BENEFIT PERIOD

*A benefit period begins on the first day you receive service as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $[652]	$[652] (Part A Deductible)	$0
61st thru 90th day	All but $[163] a day	$[163] a day	$0
91st day and after:			
—While using 60 lifetime reserve days	All but $[326] a day	$[326] a day	$0
—Once lifetime reserve days are used:			
—Additional 365 days	$0	100% of Medicare Eligible Expenses	$0
—Beyond the Additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $[81.50] a day	Up to $[81.50] a day	$0
101st day and after	$0	$0	All costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PLAN J

MEDICARE (PART B)—MEDICAL SERVICES—PER CALENDAR YEAR

*Once you have been billed $100 of Medicare-Approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES—IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
Part B Excess Charges Above Medicare Approved Amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All Costs	$0
Next $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES—BLOOD TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
—Medically necessary skilled care services and medical supplies	100%	$0	$0
—Durable medical equipment			
First $100 of Medicare Approved Amounts*	$0	$100 (Part B Deductible)	$0
Remainder of Medicare Approved Amounts	80%	20%	$0

(continued)

PLAN J (continued)

PARTS A & B (continued)

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOME HEALTH CARE (cont'd) AT-HOME RECOVERY SERVICES—NOT COVERED BY MEDICARE Home care certified by your doctor, for personal care beginning during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
—Benefit for each visit	$0	Actual Charges to $40 a visit	Balance
—Number of visits covered (must be received within 8 weeks of last Medicare Approved visit)	$0	Up to the number of Medicare Approved visits, not to exceed 7 each week	
—Calendar year maximum	$0	$1,600	
OTHER BENEFITS—NOT COVERED BY MEDICARE			
FOREIGN TRAVEL—NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of Charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum
EXTENDED OUTPATIENT PRESCRIPTION DRUGS—NOT COVERED BY MEDICARE			
First $250 each calendar year	$0	$0	$250
Next $6,000 each calendar year	$0	50%—$3,000 calendar year maximum benefit	50%
Over $6,000 each calendar year	$0	$0	All Costs
PREVENTIVE MEDICAL CARE BENEFIT—NOT COVERED BY MEDICARE Annual physical and preventive tests and services such as: fecal occult blood test, digital rectal exam, mammogram, hearing screening, dipstick urinalysis, diabetes screening, thyroid function test, influenza shot, tetanus and diptheria booster and education, administered or ordered by your doctor when not covered by Medicare			
First $120 each calendar year	$0	$120	$0
Additional charges	$0	$0	All Costs

2221 REQUIRED DISCLOSURE PROVISIONS - NOTICE REGARDING POLICIES OR CERTIFICATES WHICH ARE NOT MEDICARE SUPPLEMENT POLICIES.

2221.1 Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy; or a policy issued pursuant to a contract under section 1876 or section 1833 of the Federal Social Security Act (42 U.S.C. 1395 et seq.), disability income policy; basic, catastrophic, or major medical expense policy; single premium nonrenewable policy or other policy identified in section 2202.2 of this chapter, issued for delivery in the District of Columbia to persons eligible for Medicare by reason of age shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate.

2221.2 The notice shall either be printed or attached to the first page of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy, or certificate delivered to insureds and the notice shall be in no less than twelve (12) point type and shall contain the following language:

"THIS [POLICY OR CERTIFICATE] IS NOT A MEDICARE SUPPLEMENT [POLICY OR CONTRACT]. IF YOU ARE ELIGIBLE FOR MEDICARE, REVIEW THE MEDICARE SUPPLEMENT BUYER'S GUIDE AVAILABLE FROM THE COMPANY."

2222 REQUIREMENTS FOR APPLICATION FORMS AND REPLACEMENT COVERAGE

2222.1 Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force.

2222.2 A supplementary application or other form to be signed by the applicant and agent containing such questions and statements may be used.

(a) [Statements]

(1) You do not need more than one Medicare supplement policy.

(2) If you are 65 or older, you may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.

(3) The benefits and premiums under your Medicare supplement policy will be suspended during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted

if requested within 90 days of losing Medicaid eligibility.

(4) Counseling services may be available in the District of Columbia to provide advice concerning your purchase of Medicare supplement insurance and concerning Medicaid.

(b) [Questions] To the best of your knowledge,

(1) Do you have another Medicare supplement policy or certificate in force (including health care service contract, health maintenance organization contract)?

(A) If so, with which company?

(2) Do you have any other health insurance policies that provide benefits which this Medicare supplement policy would duplicate?

(A) If so, with which company?

(B) What kind of policy?

(3) If the answer to question 1 or 2 is yes, do you

intend to replace these medical or health policies with this policy [certificate]?

(4) Are you covered by Medicaid?

2222.3 Agents shall list any other health insurance policies they have sold to the applicant.

(a) List policies sold which are still in force.

(b) List policies sold in the past five (5) years which are no longer in force.

2222.4 In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant, and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.

2222.5 Upon determining that a sale will involve replacement of Medicare supplement coverage, any issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of Medicare supplement coverage.

(a) One copy of the notice signed by the applicant and the agent, except where the coverage is sold without an agent, shall be provided to the applicant and an additional signed

copy shall be retained by the issuer.

(b) A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of Medicare supplement coverage.

2222.6 The notice required by subsection 2222.5 for an issuer shall be provided in substantially the following form in no less than ten (10) point type:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF MEDICARE SUPPLEMENT INSURANCE

[Insurance company's name and address]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to [your application] [information you have furnished], you intend to terminate existing Medicare supplement insurance and replace it with a policy to be issued by [Company Name] Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. Terminate your present policy only if, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision.

STATEMENT TO APPLICANT BY ISSUER, AGENT [BROKER OR OTHER REPRESENTATIVE]

I have reviewed your current medical or health insurance coverage. The replacement of insurance involved in this transaction does not duplicate coverage, to the best of my knowledge. The replacement policy is being purchased for the following reason(s) (check one):

_____Additional benefits.
_____No change in benefits, but lower premiums.
_____Fewer benefits and lower premiums.
_____Other. (please specify)
_____
_____
_____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. District of Columbia law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or

probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____

(Signature of Agent, Broker or Other Representative)*

[Typed Name and Address of Issuer, Agent or Broker]

_____

(Applicant's Signature)

_____

(Date)

*Signature not required for direct response sales.

2222.7 Paragraphs 1 and 2 of the replacement notice (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

2223 FILING REQUIREMENTS FOR ADVERTISING.

2223.1 An issuer shall provide a copy of any Medicare supplement advertisement intended for use in the District of Columbia whether through written, radio or television medium to the Superintendent of Insurance for review or approval by the Superintendent to the extent it may be required under District of Columbia law.

2224 STANDARDS FOR MARKETING

2224.1 An issuer, directly or through its producers, shall:

(a) Establish marketing procedures to assure that any comparison of policies by its agents or other producers will be fair and accurate;

(b) Establish marketing procedures to assure excessive insurance is not sold or issued;

(c) Display prominently by type, stamp or other appropriate means, on the first page of the policy the following:

"Notice to buyer: This policy may not cover all of your medical expenses.";

(d) Inquire and otherwise make every reasonable effort to identify whether a prospective applicant or enrollee for Medicare supplement insurance already has accident and sickness insurance and the types and amounts of any such insurance; and

(e) Establish auditable procedures for verifying compliance with this subsection 2224.1.

2224.2 The following acts and practices are prohibited:

(a) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing, or tending to induce, any person to lapse, forfeit, surrender, terminate, retain, pledge, assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

(b) High pressure tactics. Employing any method of marketing having the effect of or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insuance.

(c) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

2224.3 The terms **"Medicare Supplement," "Medigap," "Medicare Wrap-Around"** and words of similar import shall not be used unless the policy is issued in compliance with this chapter.

2225 APPROPRIATENESS OF RECOMMENDED PURCHASE AND EXCESSIVE INSURANCE.

2225.1 In recommending the purchase or replacement of any Medicare supplement policy or certificate an agent shall make reasonable efforts to determine the appropriateness of a recommended purchase or replacement.

2225.2 Any sale of Medicare supplement coverage that will provide an individual more than one Medicare supplement policy or certificate is prohibited.

2226 REPORTING OF MULTIPLE POLICIES.

2226.1 On or before March 1 of each year, an issuer shall report the following information for every individual resident of the District of Columbia for which the issuer has in force more than one Medicare supplement policy or certificate:

(a) Policy and certificate number, and

(b) Date of issuance.

2226.2 The items set forth above must be grouped by individual policyholder.

2226.3 Appendix B contains a reporting form for compliance with this section.

2227 PROHIBITION AGAINST PREEXISTING CONDITIONS, WAITING PERIODS, ELIMINATION PERIODS AND PROBATIONARY PERIODS IN REPLACEMENT POLICIES OR CERTIFICATES.

2227.1 If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.

2227.2 If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six (6) months, the replacing policy shall not provide any time period applicable to preexisiting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

2228 EFFECTIVE DATE.

This chapter was adopted on October 1, 1992.

2299 DEFINITIONS.

2299.1 For purposes of this chapter, the words and phrases set forth in this section shall have the meanings ascribed.

Applicant

(a) In the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits, and

(b) In the case of a group Medicare supplement policy, the proposed certificateholder.

Certificate - any certificate delivered or issued for delivery in the District of Columbia under a group Medicare supplement policy.

Certificate Form - the form on which the certificate is delivered or issued for delivery by the issuer.

Issuer - insurance companies, fraternal benefit societies, health care service plans, health maintenance organizations, and any other entity delivering or issuing for delivery in the District of Columbia Medicare supplement policies or certificates. The term "issuer" includes Group Hospitalization and Medical Service, Incorporated.

Medicare - the "Health Insurance for the Aged Act," Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

Medicare Supplement Policy - a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical services associations or health maintenance organization, other than a policy issued pursuant to a contract under Section 1876 or section 1833 of the Federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project authorized pursuant to amendments to the federal Social Security Act, which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare.

Policy Form - the form on which the policy is delivered or issued for delivery by the issuer.

Appendix A

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w) _____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

line		(a) Earned Premium (x)	(b) Incurred Claims(y)
1	Current Year's Experience		
	a. Total (all policy years)		
	b. Current year's issues (z)		
	c. Net (for reporting purposes = 1a - 1b)	----------	----------
2	Past Years' Experience (All Policy Years)	----------	----------
3	Total Experience (Net Current Year + Past Years' Experience)	----------	----------
4	Refunds last year (Excluding Interest)		
5	Previous Since Inception (Excluding Interest)		
6	Refunds Since Inception (Excluding Interest)		
7	Benchmark Ratio Since Inception (SEE WORKSHEET FOR RATIO 1)		
8	Experienced Ratio Since Inception		

Total Actual Incurred Claims (line 3, col b) = Ratio 2

Tot. Earned Prem.(line 3, col a) - Refunds Since Inception(line 6)

9 Life Years Exposed Since Inception _____

If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.

10 Tolerance Permitted (obtained from credibility table) _____

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w) _____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

11 Adjustment to Incurred Claims for Credibility

Ratio 3 = Ratio 2 + Tolerance

If Ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.

If Ratio 3 is less than the benchmark ratio, then proceed.

12 Adjusted Incurred Claims =

[Tot. Earned Premiums(line 3, col a)-Refunds Since Inception(line 6)]
X Ratio 3(line 11)

13 Refund = Total Earned Premiums (line 3, col a) -
Refunds Since Inception (line 6) -

Adjusted Incurred Claims (line 12)

Benchmark Ratio (Ratio 1)

If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.

Medicare Supplement Credibility Table

Life Years Exposed Since Inception	Tolerance
10,000 +	0.0%
5,000 - 9,999	5.0%
2,500 - 4,999	7.5%
1,000 - 2,499	10.0%
500 - 999	15.0%

If less than 500, no credibility.

MEDICARE SUPPLEMENT REFUND CALCULATION FORM
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (w) _____
For the State of _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

(w) "SMSBP" = Standardized Medicare Supplement Benefit Plan
(x) Includes modal loadings and fees charged.
(y) Excludes Active Life Reserves.
(z) This is to be used as "Issue Year Earned Premium" for Year 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief.

_____
Signature

_____
Name - Please Type

_____
Title

_____
Date

REPORTING FORM FOR THE CALCULATION OF
BENCHMARK RATIO SINCE INCEPTION
FOR GROUP POLICIES
FOR CALENDAR YEAR _____

TYPE _____ SMSBP (p)
FOR THE STATE OF _____
Company Name _____
NAIC Group Code _____ NAIC Company Code _____
Address _____
Person Completing This Exhibit _____
Title _____ Telephone Number _____

(a) Year	(b) Earned Premium	(c) Factor	(d) (b) x (c)	(e) Cumulative Loss Ratio	(f) (d) x (e)	(g) Factor	(h) (b) x (g)	(i) Cumulative Loss Ratio	(j) (h) x (i)	(o) Policy Year Loss Ratio
1		2.770		0.507		0.000		0.000		0.46
2		4.175		0.567		0.000		0.000		0.63
3		4.175		0.567		1.194		0.759		0.75
4		4.175		0.567		2.245		0.771		0.77
5		4.175		0.567		3.170		0.782		0.8
6		4.175		0.567		3.998		0.792		0.82
7		4.175		0.567		4.754		0.802		0.84
8		4.175		0.567		5.445		0.811		0.87
9		4.175		0.567		6.075		0.818		0.88
10		4.175		0.567		6.650		0.824		0.88
11		4.175		0.567		7.176		0.828		0.88
12		4.175		0.567		7.655		0.831		0.88
13		4.175		0.567		8.093		0.834		0.89
14		4.175		0.567		8.493		0.837		0.89
15		4.175		0.567		8.684		0.838		0.89
Total										
			(k):		(l):		(m):		(n):	

Benchmark Ratio Since Inception: (l + n) / (k + m):

(a): Year 1 is the current calendar year - 1
Year 2 is the current calendar year - 2
(etc.)
(Example: If the current year is 1991, then:
Year 1 is 1990; Year 2 is 1989; etc.)

(b): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(o): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(p): "SMSBP" = Standardized Medicare Supplement Benefit Plan

APPENDIX B

FORM FOR REPORTING
MEDICARE SUPPLEMENT POLICIES

Company Name: _____

Address: _____

_____

Phone Number: _____

Due: March 1, annually

The purpose of this form is to report the following information on each resident of this state who has in force more than one Medicare supplement policy or certificate. The information is to be grouped by individual policyholder.

Policy and Certificate #	Date of Issuance

_____
Signature

_____
Name and Title (please type)

_____
Date